

**ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF VITAL RECORDS
NOTICE OF CLAIM OF PATERNITY**

NAME OF CHILD (if born) _____
First Middle Last

DATE OF BIRTH _____
Month Day Year

ESTIMATED DATE OF BIRTH (if not born) _____
Month Year

PLACE OF BIRTH _____
City County State

NAME OF MOTHER _____
First Middle Last

MOTHER'S MAIDEN NAME (if different) _____
First Middle Last

MOTHER'S RESIDENCE ADDRESS (last known) _____

City State Zip Code

NAME OF FATHER _____
First Middle Last

FATHER'S RESIDENCE ADDRESS _____

City State Zip Code

I hereby claim paternity of the child identified above. This is to signify my intention to prove paternity through further legal action and my willingness and interest to support this child to the best of my ability.

SIGNATURE OF FATHER _____ DATE SIGNED _____

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, of _____

Notary Signature _____

My Commission Expires _____

SEAL

MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC

INSTRUCTIONS

1. Type or print all required information except where signatures are required. **DO NOT USE PENCIL.**
2. Signatures and printed information must be entered using black ink or black ribbon.
3. Alterations, erasures, eradications, etc., will invalidate this form.
4. Do not submit this form if it contains alterations.
5. This document must be signed in the presence of a Notary Public.
6. There is no fee to file this form.
7. You can mail this form to:

Office of Vital Records
PO Box 3887
Phoenix, Arizona 85030

Or, you can bring this form in person to:

Office of Vital Records
1818 West Adams Street
Phoenix, Arizona 85007